WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
FAMILY PLANNING PROGRAM

WEST VIRGINIA Department of Health & Human Resources
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Office of Maternal, Child and Family Health

PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

NAME:	BIRTHDATE:	AGE:	DATE:

ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? □ YES □ NO

IF YOUR ANSWER TO A QUESTION IS YES, PUT A CHECK MARK ON THE LINE IN FRONT OF THE QUESTION. FILL IN OTHER INFORMATION THAT APPLIES TO YOU.

DIET & EXERCISE

____ What do you consider a healthy weight for you?
____ Do you eat three meals a day?
____ Do you follow a special diet (vegetarian, diabetic, other)?
____ Which do you drink (__coffee __tea __milk __water __soda/pop Other _____)?
____ Do you eat raw or undercooked food (meat, other)?
____ Do you take folic acid?
____ Do you take other vitamins daily (__multivitamin __vitamin A __other)?
____ Do you take dietary supplements (__black cohosh __pennyroyal __other)?
____ Do you exercise? Type/frequency: _____

MEDICATION/DRUGS

____ Are you taking prescribed drugs (Accutane, valproic acid, blood thinners)? List them: _____
____ Are you taking non-prescribed drugs? List them: _____
____ Are you using birth control pills?
____ Do you get injectable contraceptives or shots for birth control?
____ Do you use any herbal remedies or alternative medicine? List them: _____

WOMEN'S HEALTH

____ Do you have any problems with your menstrual cycle?
____ How many times have you been pregnant? What was/were the outcome(s)? _____
____ Did you have difficulty getting pregnant last time?
____ Have you been treated for infertility?
____ Have you had surgery on your uterus, cervix, ovaries or tubes?
____ Did your mother take the hormone DES during pregnancy?
____ Have you ever had HPV, genital warts or chlamydia?
____ Have you ever been treated for a sexually transmitted infection (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)? List: _____

HOME ENVIRONMENT

____ Do you feel emotionally supported at home?
____ Do you have help from relatives or friends if needed?
____ Do you feel you have serious money/financial worries?
____ Are you in a stable relationship?
____ Do you feel safe at home?
____ Does anyone threaten or physically hurt you?
____ Do you have pets (cats, rodents, exotic animals)? List them: _____
____ Do you have any contact with soil, cat litter or sandboxes?

Baby preparation (if planning pregnancy):
____ Do you have a place for a baby to sleep?
____ Do you need any baby items?

LIFESTYLE

____ Do you smoke cigarettes or use other tobacco products? How many cigarettes/packs a day? _____
____ Are you exposed to second-hand smoke?
____ Do you drink alcohol? What kind? _____ How often? _____ How much? _____
____ Do you use recreational drugs (cocaine, heroin, ecstasy, meth/ice, other)? List: _____
____ Do you see a dentist regularly? What kind of work do you do? _____
____ Do you work or live near possible hazards (chemicals, x-ray or other radiation, lead)? List: _____
____ Do you use saunas or hot tubs?

MEDICAL/FAMILY HISTORY

Do you have or have you ever had:

____ Epilepsy?
____ Asthma?
____ Heart disease?
____ Kidney or bladder disorders?
____ Thyroid disease?
____ Digestive problems?
____ High blood pressure?
____ Depression or other mental health problems?
____ Diabetes?
____ Lupus?
____ Anemia?
____ Chickenpox?
____ Hepatitis C
____ Scleroderma?
____ Other conditions?

Have you ever been vaccinated for:

____ Measles, mumps, rubella?
____ Chickenpox
____ Hepatitis B?

GENETICS

Does your family or your partner's family have a history of:

	Yours:	Your partner's:
____ Hemophilia?	____	____
____ Other bleeding disorders?		
____ Tay-Sachs disease?	____	____
____ Blood diseases (sickle cell, thalassemia, other)?	____	
____ Muscular dystrophy?		____
____ Downs syndrome?		____
____ Intellectual and/or Developmental Disabilty?		____
____ Cystic Fibrosis?	____	
____ Birth Defects (spine/heart/kidney)?		____

Your ethnic background is: _____
Your partner's ethnic background is: _____

OTHER

Is there anything else you'd like to know? _____

Are there any questions you'd like to ask me? _____

NOTES